Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: OXMED INC PO BOX 972557 DALLAS TX 75397-2557	MFDR Tracking #: M4-04-4306-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: DALLAS ISD Box #: 42	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "We feel that we are due our full billed amount for the equipment provided to this patient. The carrier has incorrectly reviewed this claim and has paid this claim at a reduced rate. We have provided this carrier with examples of payments in full for the same type of billed service. These items are billed at a fair & reasonable rate according to the Commission Rules and Fee Guidelines. These claim items were submitted based on the 1991 Fee Guidelines and should have been paid accordingly. We have provided the carrier with examples of payments in full to substantiate the amount billed on the HCFA-1500 and are now requesting the remaining amount to be paid in **Full** with accrued **interest.**"

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $459.91

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
5/13/2003	E0236	$490.20 minus carrier paid $144.26 = $345.94	$349.74	$345.94
	E1399	Not Applicable	$15.00	$0.00
	E1399	Not Applicable	$31.00	$0.00
	E0114	$35.10 minus carrier paid $67.83 = $0.00	$42.17	$0.00
	E0245	$117.00 minus carrier paid $88.00 = $29.00	$22.00	$22.00
			Total Due:	$367.94

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on December 9, 2003. Pursuant to

Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 16, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.

2. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
3. Texas Labor Code §413.011 requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
4. Division rule at 28 TAC §134.201, titled *Medical Fee Guideline for Medical Treatments and Services Provided Under the Texas Workers' Compensation Act*, effective April 1, 1996, sets out the reimbursement for medical treatment.
5. Division rule at 28 TAC §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedure for medical fee dispute resolution.
6. Division rule at 28 TAC §133.304, effective July 15, 2000, 25 TexReg 2115, requires the insurance carrier to develop and consistently apply a methodology to determine fair and reasonable reimbursement.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 6/11/2003

   - R4-Charge unrelated to the compensable injury. The supplies/service are not (or appear not to be) related to the worker's compensation injury of this claimant.

   Explanation of benefits dated 7/9/2003

   - 01-TWCC Code: O-Denial after reconsideration. Upon review of your request for reconsideration, no additional benefit is recommended.

   Explanation of benefits dated 9/4/2003

   - S53-TWCC Code: S-Supplemental payment. Upon final audit, additional benefit is recommended for the billed service(s).

Issues

1. Does a compensability issue exist in this dispute?
2. What is the applicable rule for reimbursement?
3. Is the requestor entitled to additional reimbursement for HCPCS E0236?
4. Is the requestor entitled to additional reimbursement for HCPCS E1399?
5. Is the requestor entitled to additional reimbursement for HCPCS E0114?
6. Is the requestor entitled to additional reimbursement for HCPCS E0245?

Findings

1. Based upon the Division records, an agreement was reached between the parties that the compensable injury was to the claimant's neck, back, left knee and left ankle. Upon reconsideration this denial was not maintained and payment was made based upon fair and reasonable methodology. Therefore, the Division considers that there are no unresolved issues of compensability and only fee issues remain.
2. Division rule at 28 TAC §134.201, titled *Medical Fee Guideline for Medical Treatments and Services Provided Under the Texas Workers' Compensation Act*, effective April 1, 1996, DURABLE MEDICAL EQUIPMENT (DME) GROUND RULE IV, titled Nonlisted Items and Documentation of Procedure states that "This document does not contain a specific MAR for DME items. The DME items should be billed at the usual and customary rate of the DME provider, and the insurance carrier shall reimburse the DME provider at an amount pre-negotiated between the provider and carrier, or, if there is no pre-negotiated amount, the fair and reasonable rate for the item described. Use the miscellaneous HCPCS code, E1399, when no other HCPCS code is present for the DME or supplies provided to the injured worker. When using E1399, a description of the unlisted equipment/supply is required."

   Review of the documentation submitted by the parties to this dispute finds no documentation to support that an amount was pre-negotiated between the provider and carrier for the disputed HCPCS codes; therefore, the insurance carrier shall reimburse the provider the fair and reasonable rate for the item described per Division rule at 28 TAC §134.201 DME GROUND RULE IV.
3. HCPCS code E0236 is described as "Pump for water circulating pad." Division rule at 28 TAC §134.201, DME

GROUND RULE IX, C, titled Billing states "The provider shall use the HCFA-1500 Form for billing. Invoices should be billed at the provider's usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier of there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the 'D' codes in the 1991 Medical Fee Guideline." A review of the 1991 MFG finds this HCPCS code is comparable to MFG 1991 "D" code "D0368-Pump for water-circulating pad." Per the 1991 MFG, "D" code D0368 has a purchase price of $490.20. The insurance carrier paid $144.26. The requestor is due the difference of $345.94.

4. HCPCS code E1399 is described as "Durable Medical Equipment, miscellaneous". The requestor noted on the medical bill that HCPCS code E1399 was used for billing of a cold therapy cooler wrap and a water circulating pad. Therefore, the requestor submitted a descriptor in accordance with Division rule at 28 TAC §134.201 DME GROUND RULE (IV).

   Division rule at 28 TAC §134.201, DME GROUND RULE IX, C, titled Billing states fair and reasonable rate will be the fees set in the 1991 MFG. A review of the 1991 MFG does not find a comparable code for a cold therapy cooler wrap and a water circulating pad; therefore, reimbursement shall be at a fair and reasonable rate pursuant to Division rule at 28 TAC §134.1.

   Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d), requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines

   Division rule at 28 TAC §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor's rationale for increased reimbursement from the Table of Disputed Services does not discuss or explain how additional payment of $15.00 and $31.00 for HCPCS code E1399 would result in a fair and reasonable reimbursement.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - In support of the requested reimbursement, the requestor submitted redacted EOBs for services that are similar to the services in dispute. However, the requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. The reimbursement methodology is not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss or provide documentation to support whether such payment, as reflected in the sample EOBs, was typical for the services in dispute.
   - HCPCS code E1399 is a miscellaneous durable medical equipment code. No descriptions of the items reimbursed were found on the sample EOBs. No documentation was found to support that the miscellaneous items reimbursed on the sample EOBs were the same or similar to the items in dispute.
   - The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

   The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services billed under HCPCS code E1399. Additional payment cannot be recommended.

5. HCPCS code E0114 is described as "Crutches underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips." Division rule at 28 TAC §134.201, DME GROUND RULE IX, C, titled Billing states fair and reasonable rate will be the fees set in the 1991 MFG. This HCPCS code is comparable to MFG 1991 "D" code "D0615-Crutches, wood (pr)." Per the 1991 MFG, "D" code D0615 has a purchase price of $35.10. The insurance carrier paid $67.83. As a result, no additional payment is recommended.

6. HCPCS code E0245 is described as "Tub stool or bench." Division rule at 28 TAC §134.201, DME GROUND RULE IX, C, titled Billing states fair and reasonable rate will be the fees set in the 1991 MFG. This HCPCS code is comparable to MFG 1991 "D" code "D0241-Tub, stool or bench, basic plastic." Per the 1991 MFG, "D" code D0241 has a purchase price of $117.00. However the billed amount is $110.00. The insurance carrier paid $88.00. The

difference is $22.00 from amount billed; this amount is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor for HCPCS codes E1399 and E0114. For the reasons stated above, the division finds that the requestor has established that additional reimbursement of $367.94 is due for HCPCS code E0236 and E0245. As a result, the amount ordered is $367.94.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $367.94 reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $367.94 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**June 7, 2010**
		Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.